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Missouri Division of Medical Services

www.dss.state.mo.us/dms

Special Bulletin

Provider Communications
(800) 392-0938
or
(573) 751-2896

ICD-9-CM DIAGNOSIS CODE CHANGES

A number of diagnosis codes have been identified as new, revised, or invalid as published in the Federal Register, Volume 66, Number 148, dated August 1, 2001. These new, revised, or invalid diagnosis codes are effective for all dates of services beginning October 1, 2001. There will be a 90-day grace period between October 1, 2001, and January 1, 2002, during which claims may be submitted with the 2001 or the 2002 ICD-9-CM code versions. However, claims received on or after January 1, 2002, must include the latest version (2002) of the ICD-9-CM codes.

NOTE: Please reference the 2002 ICD-9-CM Code Book for descriptions of the diagnosis codes.

NEW DIAGNOSIS CODES

256.31, 256.39, 277.7, 464.00, 464.01, 464.50, 464.51, 521.00, 521.01, 521.02, 521.03, 521.04, 521.05, 521.09, 525.10, 525.11, 525.12, 525.13, 525.19, 530.12, 564.00, 564.01, 564.02, 564.09, 602.3, 608.82, 608.87, 692.76, 692.77, 718.70, 718.71, 718.72, 718.73, 718.74, 718.75, 718.76, 718.77, 718.78, 718.79, 733.93, 733.94, 733.95, 772.10, 772.11, 772.12, 772.13, 772.14, 779.7, 793.80, 793.81, 793.89, 840.7, 997.71, 997.72, 997.79, V10.53, V45.84, V49.82, V83.01, V83.02,

REVISED CODES

411.81, 493.00, 493.10, 493.20, 493.90, V70.7

INVALID DIAGNOSIS CODES

256.3, 464.0, 521.0, 525.1, 564.0, 772.1, 793.8

50 MODIFIER

Effective January 1, 2002, covered Missouri Medicaid procedures that are performed bilaterally and are identified by Medicare as appropriate bilateral procedures, must be billed using the 50 modifier. For bilateral procedures identified by Medicare, please reference Medicare Provider News MCB 2001-01.SB dated June 2001. When billing a procedure identified as bilateral, providers must bill using the 50 modifier and quantity of one (1).

FQHC BILLING FOR THE NORPLANT (CONTRACEPTIVE) SYSTEM

All providers were notified in Special Bulletin, Vol. 23, No. 11, dated June 8, 2001, that the "W1" modifier would no longer be used with surgical procedures performed in a physician's office effective for dates of service beginning July 1, 2001. In follow-up to the Special Bulletin, FQHC providers received instructions for the billing of the Norplant System in Remittance Advice messages dated August 10, 2001, and August 24, 2001. The elimination of the "W1" modifier requires that FQHC providers bill procedure code 11975 without the "W1" modifier for the insertion of the implant and procedure code 11977 without the "W1" modifier for the removal and reinsertion of the implant. Procedure code Z2082 must be billed for the Norplant device.

MISSOURI'S BREAST AND CERVICAL CANCER CONTROL PROJECT

Missouri women who are diagnosed with breast or cervical cancer under the state's Breast and Cervical Cancer Control Project (BCCCP) may be eligible to receive treatment through the Missouri Medicaid program.

Signed into law, full Medicaid coverage was made available effective August 28, 2001 for uninsured women under the age of 65 who have been screened through Missouri's Breast and Cervical Cancer Control Project (BCCCP), are in need of treatment for breast or cervical cancer may qualify. This includes treatment of certain precancerous conditions and early stage cancer.

Eligibility Criteria

To qualify for Medical Assistance based on the need for Breast or Cervical Cancer Treatment (BCCT) ***all*** of the following eligibility criteria must be met:

- Screened by a Missouri BCCCP Provider.
- Need for treatment for breast or cervical cancer including certain precancerous conditions.
- Under the age of 65 years old.
- Have a Social Security Number.
- Citizenship or alien status.
- Uninsured, or have health coverage that does not cover breast or cervical cancer treatment.
- A Missouri Resident.

Presumptive Eligibility (PE)

Presumptive Eligibility (PE) determinations are made by BCCCP Medicaid providers. When a BCCCP provider determines a woman is eligible for Presumptive Eligibility, they will issue her a Medicaid approval letter. Medicaid coverage under Presumptive Eligibility begins on the date the BCCCP provider determines the woman is in need of treatment.

Medicaid Coverage

Medicaid coverage under Breast and Cervical Cancer Treatment (BCCT) begins on the first day of the month of an approved application and continues until the last day of the month that the regular Medicaid application is approved or BCCT is no longer required, whichever is later. Coverage cannot begin prior to August 28, 2001.

Services can be obtained from enrolled Medicaid providers on a fee-for-service basis. Recipients eligible based on the need for BCCT are not enrolled in managed care.

Presumptive Eligibility (PE),

BCCT and regular Medicaid eligibility provide full Medicaid benefits.

For additional information and to learn where the closest BCCCP provider is located call the Cancer Information Service at
1 - 8 0 0 - 4 C A N C E R
which translates to:
1-800-422-6227.